Maryland
DEPARTMENT OF HEALTH

Preparing for and Responding to COVID-19 in Long-term Care and Assisted Living Facilities

Given their congregate nature and residents served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at the highest risk of being affected by coronavirus disease 2019 (COVID-19). If infected with SARS-CoV-2, the virus that causes COVID-19, residents are at increased risk of serious illness. The following recommendations from Maryland Department of Health (MDH) supplement CDC's general infection prevention and control recommendations for COVID-19 and CDC's Preparation for COVID-19 in Long-term Care. The following recommendations should continue until otherwise determined by public health.

COVID-19 Description

Typical symptoms include fever, cough, and shortness of breath. Additional symptoms might include sore throat, fatigue/malaise, diarrhea, or dizziness.

Case Definitions

Undiagnosed respiratory illness: Cough, shortness of breath, pneumonia, or fever in a resident or an employee without a known cause.

- No known contact with a COVID-19 case, does not reside in or work at a facility with confirmed cases within 14 days.
- Influenza testing, respiratory panel and COVID-19 testing is not done or pending. Sputum culture, *Legionella* urinary antigen and *Streptococcus pneumoniae* urinary antigen testing for pneumonia cases is not done or pending.

Suspect COVID-19 case: Clinical illness as above in an individual **AND:**

- Has known contact with a COVID-19 case **OR** resides or works at a facility with confirmed cases within the past 14 days; **OR**
- Does not have known contact with a COVID-19 case and does not reside or work at a facility with confirmed cases within the past 14 days **AND** who tested negative for influenza on initial workup and no alternative diagnosis.

Confirmed COVID-19 case: an individual with a positive SARS-CoV-2 test regardless of signs and symptoms

Testing/Laboratory Diagnosis:

COVID-19 testing:

- Facilities should evaluate their capacity to safely collect specimens for COVID-19 testing.
- Facilities should assess supplies of testing kits and the potential for acquiring additional specimen collection kits from private laboratories. They should also consult with their local health department (LHD) to ask about the availability of COVID test kits.
- Facilities should develop a protocol for specimen collection in collaboration with public health.

All residents with undiagnosed respiratory illness:

- Test for influenza and other agents utilizing the following tests. Facilities are encouraged to use a private laboratory. If no private lab testing is available, contact your LHD.
    - Rapid flu and influenza PCR and respiratory panel if the PCR test is negative; **OR**
    - Rapid flu and respiratory panel

Pneumonia cases:
In addition to the above tests, run the following tests simultaneously:

- Sputum culture, including for *Legionella*
- *Legionella* and *Streptococcus pneumoniae* urinary antigen tests

If all testing listed above is negative or results are not available within 48 hours **notify your LHD AND** send specimens for COVID-19 testing to a private lab or request testing from the LHD.

Testing for staff:

- Facilities should make arrangements/encourage symptomatic staff to be evaluated and have testing as above for residents.
- Facilities should encourage ill staff to seek medical advice from their own healthcare providers or from occupational health.

Outbreak definitions:

COVID-19 outbreak: One or more confirmed cases of COVID-19 in a resident or staff member.

Other respiratory outbreaks (see respiratory guidelines for managing these outbreaks):

- Influenza-like illness (ILI) outbreak: 3 or more ILI cases in 7 days
- Influenza outbreak: 2 residents and/or staff with ILI or pneumonia within 7 days and at least one has a positive influenza test
- Pneumonia outbreak: 2 or more cases of pneumonia in a unit within 7 days
- A combination of ILI, influenza, and pneumonia cases

What to report - the following scenarios must be reported to LHD:

- Immediate reporting
  - One or more confirmed COVID-19 cases among residents and/or staff
  - Two or more undiagnosed respiratory illnesses or suspect COVID-19 cases within 14 days
  - One case of undiagnosed respiratory illness or suspect COVID-19 case where laboratory results will not be available within 48 hours **AND** illness is severe
- Within one day
  - Respiratory outbreaks as defined in the respiratory outbreak guidelines
  - One case of undiagnosed respiratory illness or suspect COVID-19 case where laboratory results will not be available within 48 hours (illness not severe)

Preventive Measures Against COVID-19

Share the latest information about COVID-19 with staff, residents, and families

Educate and train healthcare personnel (HCP):

- Reinforce adherence to infection prevention and control measures, including hand hygiene and selection and use of personal protective equipment (PPE).
- Have HCP demonstrate competency with putting on and removing PPE.
- Implement or continue program for observing and monitoring adherence to hand hygiene and PPE, all days and shifts

Reinforce sick leave policies:

- **Staff should not report to work ill.** Signs and symptoms of COVID-19 can be very mild, so even mild signs of respiratory illness should result in HCP exclusion.
- Staff should be actively monitored for signs and symptoms of respiratory illness. At the start of each shift, HCP should be required to check their temperature and report whether they are experiencing any signs and symptoms of respiratory illness.
- Active monitoring should be repeated every 8 hours and as needed.
- Any staff that develop signs and symptoms of respiratory illness while working should promptly don a face mask and be sent home.
- Staff may return to work after at least 7 days since symptoms first appeared **AND** at least 3 days (72 hours) since recovery, defined as resolution of fever without the use of fever-reducing meds **AND** improvement in respiratory symptoms.
- If staff shortages are experienced by a facility, they should consult their local health department to determine whether any staff may return to work earlier than recommended to address the need for staffing.

Ensure adequate supplies for infection prevention and control practices:

- Assess supply of PPE and initiate measures to optimize current supply.
- Alcohol-based hand sanitizer should be available inside and outside of every resident room and other resident care and common areas.
- Sinks should be kept well stocked with soap and paper towels for handwashing.
- PPE should be readily available and kept well stocked in areas where resident care is provided.

Identify infections early:

- Actively screen all residents every shift for fever and respiratory symptoms; immediately isolate anyone who is symptomatic. Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Additional symptoms may include new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should result in prompt isolation and further evaluation for COVID-19 if it is circulating in the community.
- All residents with undiagnosed respiratory illness should be cared for using standard, contact, and droplet precautions with eye protection (i.e. gown, gloves, facemask, and face shield or goggles), at least until diagnosis is clarified.

Admissions and readmissions:

- Create a dedicated observation area (this could be a separate unit/wing if possible or dedicated rooms in one area) to house non-COVID-19-positive residents being admitted or re-admitted from an outside facility. Ideally, this area would have private rooms with private bathrooms.
- Patients being admitted to this area do not need to be tested for COVID-19 prior to admission. They should be screened for COVID-19 symptoms prior to admission using the following methods:
    - Verbal report received from the transferring facility
    - Temperature taken (cutoff for fever is >100.0F)
    - Questions asked about symptoms: cough, shortness of breath, sore throat, fatigue/malaise, diarrhea, dizziness
- If a new resident screens positive, they need to be placed on strict isolation (contact and droplet precautions with eye protection) and not allowed to mix with any other residents.
- If a new resident screens negative, they should be admitted to this observation unit/area for 14 days. They can mix with other residents in this unit/area but not with other residents in the facility. They should also be screened daily with temperature and symptom checks and placed on strict isolation if they screen positive.
- After 14 days on the observation unit, if the resident does not ever screen positive, they can be released to mix with the general population.
- Patients who have been hospitalized for suspect or confirmed COVID-19 can be discharged from the hospital whenever it is clinically indicated. They do **NOT** require re-testing to be discharged.
- A nursing home can accept a resident diagnosed with COVID-19 and still under Transmission-Based Precautions for COVID-19 as long as the facility can follow CDC guidance for Transmission-Based Precautions. If a nursing home cannot follow this guidance, it must wait until these precautions are discontinued.
- The placement of newly admitted residents who have been previously diagnosed with suspect or confirmed COVID-19 should be based on whether they still require the use of Transmission-Based Precautions:
    - Patients who meet criteria for discontinuation of Transmission Based Precautions for COVID-19 can be admitted to the general population using Standard Precautions.
    - Patients who do not yet meet criteria for discontinuation of Transmission Based Precautions for COVID-19 should be admitted to a private room with a private bathroom on Standard, Contact, and Droplet Precautions (including eye

protection). These patients should be isolated to their rooms except for necessary medical procedures until they meet criteria for the discontinuation of Transmission Based Precautions.

Discontinuation of Transmission-Based Precautions:

- Does not require patients to be tested or re-tested for COVID-19
- Guidance for discontinuation of in-home isolation precautions is the same as that to discontinue Transmission-Based Precautions for hospitalized patients with COVID-19 and is as follows:
    - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); **AND**
    - At least 7 days have passed *since symptoms first appeared*.
- If the patient was never tested for COVID-19 but was suspected to have the illness, the criteria for discontinuation of Transmission Based Precautions should still be followed.

Visitor and movement restrictions:

- All visitors should be restricted from entering the facility except for in extenuating circumstances (e.g. a resident is at the end of life).
- Potential visitors must be screened prior to entry for fever or respiratory symptoms. Those with symptoms are not permitted to enter the facility.
- Visitors that are permitted inside must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility. They are also reminded to frequently perform hand hygiene.
- Cancel communal dining and all group activities in the facility.
- Encourage social distancing. Encourage residents to remain in their room to the extent possible.
- Have residents who must regularly leave the facility for medically necessary purposes (e.g., residents receiving hemodialysis) wear a facemask whenever they leave their room, including for procedures outside of the facility.

Communication:

- Prepare facility internal and external communications in the event of a COVID-19 case being identified in your facility.
- Brief leadership team on priority activities in the event of a suspected or confirmed case (e.g. ensuring vigilant infection control).
- Have an updated phone tree with public health communicable disease contacts and leadership contacts readily accessible.

When You Have Undiagnosed Respiratory Illness(es) or Suspected COVID-19 Case(s)

Please note: Activities implemented before a suspected/confirmed case still apply

Admissions and transfers:

- Unit or facility closure should be discussed with public health.
- If a resident suspected for COVID-19 requires a higher level of care or the facility cannot fully implement all recommended precautions, the resident should be transferred to another facility that is capable of implementation.

- Transport personnel and the receiving facility must be verbally notified about the suspected diagnosis prior to transfer.
- While awaiting transfer, symptomatic residents should wear a facemask (if tolerated) and be separated from others (e.g., kept in their room with the door closed). Appropriate PPE should be used by HCP when coming in contact with the resident.

Environmental cleaning:

- Frequently touched surfaces should be disinfected three times per day and as needed (e.g. tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks & cell phones) with an EPA-registered disinfectant on List N with an emerging pathogens or human coronavirus claim or a 1:10 bleach solution.
- Environmental services staff should wear appropriate PPE (i.e. gown, gloves, and face mask with eye protection) when cleaning the room of any resident for daily and terminal cleaning.
- To the extent possible, dedicate medical equipment to residents with fever or signs and symptoms of respiratory illness.
- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.

Care of residents:

- Use Standard, Contact and Droplet precautions with eye protection (i.e. gown, gloves, face mask, and face shield or goggles) for ill residents.
- Your local health department can assist with resident placement decisions.
- Create a plan, in collaboration with public health, for cohorting residents with symptoms of respiratory infection, including dedicating HCP to work only with ill or well residents and/or dedicating a wing or space for suspected or confirmed COVID-19 residents.
- Aerosol-generating procedures should be avoided. If unavoidable, they should ideally be performed in an airborne infection isolation room (AIIR) or if not possible, in a private, closed room with a close door while wearing appropriate PPE (i.e. gown, gloves, N95 or higher-level respirator, and eye protection).

When You Have Confirmed COVID-19 Case(s)

Please note: Activities implemented before confirming a COVID-19 case still apply

Response priorities:

When a COVID-19 case(s) is confirmed:

- Quick identification and isolation of residents and exclusion of HCP with signs and symptoms
- Strict active monitoring of all residents and facility staff members
- Compliance with strict visitor restrictions
- Correct donning and doffing of PPE
- Reinforcement of hand hygiene practices and respiratory etiquette for staff and residents
- Enhanced environmental cleaning of frequently touched surfaces three times per day
- Frequent, transparent communication with public health

Communication:

- Inform residents (and family) and staff of confirmed case(s) with prepared communication materials.
- Discuss response to confirmed case(s) with public health authorities.
- Complete staff/leadership rounds at the facility on every shift to ensure staff have an opportunity to discuss concerns with leadership.
- Coordinate public communications with state and local authorities.

Personal protective equipment (PPE):

- Implement universal masking of all staff and essential visitors at the facility.
- If PPE supply allows, consider having HCP wear all recommended PPE (gown, gloves, eye protection, facemask) for the care of all residents, regardless of presence of symptoms.
- Restrict all residents to their rooms except for medically necessary purposes.